



## INSURANCE ADMINISTRATION

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### PHARMACY BENEFIT MANAGER REGISTRATION APPLICATION

This Application Form is required for Pharmacy Benefit Manager Registration pursuant to Title 15, Subtitle 16 of the Insurance Article, Annotated Code of Maryland.

#### Section 1 - Application Information (check applicable items)

☐ Initial Registration Application

☐ Renewal Registration Application

Currently certified in Maryland as a Private Review Agent? Yes ☐ No ☐

Currently registered in Maryland as a Third Party Administrator? Yes ☐ No ☐

#### Section 2 - Applicant (Business Entity) Information

Applicant Name

DBA/Trade Name(s)

FEIN #

Business Address

Phone Number

Fax Number

Web Site

#### Section 3 - Applicant Contact Information

Name

Title

Phone Number

E-mail Address

Mailing Address (if other than provided in Section 2)

**Section 4 - Applicant Background Information. Attach a full explanation and/or the requested information for any questions answered "Yes" as an Attachment to this Application. Failure to provide the required Attachments may result in the Application being returned unprocessed or considered deficient.**

Has the Applicant been refused a registration, license or certification to act as a pharmacy benefit manager, or has had any registration, license or certification to act as such been denied, suspended, revoked or non-renewed for any disciplinary reason in any state?

o Yes

o No

Has the Applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal or dishonest activities in connection with the administration of pharmacy benefits management services?

o Yes

o No

Has the Applicant had a business relationship with an insurance company terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of pharmacy benefits management services?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Section 5 – Pharmacy Benefit Manager Operations. Attach a full explanation for any questions answered "No" as an Attachment to this Application. Failure to provide the required Attachments may result in the Application being returned unprocessed or considered deficient.</b>		
Does the Applicant ship, mail or deliver prescription drugs or devices to a person in Maryland only through a nonresident pharmacy that holds a permit issued in accordance with §12-403 of the Health Occupations Article?	<input type="radio"/> Yes	<input type="radio"/> No
Does the Applicant's Pharmacy and Therapeutics Committee meet the requirements of §§15-1613, 15-1614, 15-1615, 15-616, and 15-617 of the Insurance Article or does the Applicant meet these requirements because the Applicant has accreditation from an accreditation organization approved by the Commissioner?	<input type="radio"/> Yes	<input type="radio"/> No
Does the Applicant provide all the disclosures to Purchasers required under §§15-1622, 15-1623, and 15-1624 of the Insurance Article?	<input type="radio"/> Yes	<input type="radio"/> No
Does the Applicant conduct audits of pharmacies and pharmacists in accordance with the provisions of §15-1629 of the Insurance Article?	<input type="radio"/> Yes	<input type="radio"/> No
Does the Applicant have an internal grievance process for pharmacies that complies with the provisions of §15-1630 of the Insurance Article?	<input type="radio"/> Yes	<input type="radio"/> No
If the Applicant conducts therapeutic interchange, does the Applicant's program comply with the requirements of §§15-1634, 15-1635, 15-1636, 15-1637 and 15-1638 of the Insurance Article?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Section 6– Applicant Certification and/or Attestation</b>		
<p><b>WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF REGISTRATION.</b></p> <p>The information required herein is continuing in nature and, as the individual responsible for preparing this document, I agree to furnish an update on any information in this application.</p> <p>As the authorized representative of the Applicant, I hereby certify under penalty of perjury, that:</p> <p>All of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for revocation or denial of registration and may subject me to civil or criminal penalties. Applicant understands and will comply with the insurance laws and regulations of the State of Maryland to which application for registration is hereby made:</p>		
<hr/> Signature		<hr/> Date
<hr/> Printed Name		<hr/> Title

#### Section 7 – Applicant Registration Fee

☐ **Intitial Registration:**

Registrant shall pay a non-refundable fee to the State of Maryland in the amount of \$250. Registration expires on the date 2 years following the date the registration is issued, unless it is renewed. Before a registration expires, it may be renewed for an additonal 2-year term.

☐ **Renewal Registration:**

Registrant shall shall pay a non-refundable fee to the State of Maryland in the amount of \$150. An application for renewal of registration shall be considered made in a timely manner if it is postmarked or otherwise delivered on or before the registration expires.

All fees should be made payable to the **Maryland Insurance Administration** by check or money order.